Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Pulmonary Arterial Hypertension Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information						
Preferred Agents:	☐ Sildenafil	☐ Epoprostenol	☐ Letairis	☐ Tracleer	☐ Flolan	☐ Revatio suspension

Non-Preferred Agents:					
	☐ tadalafil	☐ Adempas	☐ Orenitram	☐ Revatio	☐ Uptravi
	☐ Remodulin	☐ Opsumit	☐ Tyvaso	☐ Ventavis	☐ Veletri
	☐ Revatio	☐ Treprostinil	☐ Other, please specify:		

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

For continuation of therapy requests ONLY (check that apply):	☐ Response to therapy	☐ Maintained OR achieved low risk profile (improvement in 6 MWD, functional class OR reducing time to clinical worsening)

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

What medication(s) has member tried and failed for this diagnosis? Please specify:

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:	ICD-10 Code:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: ______________________________

Clinical Information - General Authorization Criteria					
Is there evidence of right heart catheterization with mPAP ≥25mm Hg?	☐ Yes	☐ No	Is diagnosis of PAH WHO Group I with Functional Class II to IV symptoms?	☐ Yes	☐ No
Did member have a negative vasoreactivity test?	☐ Yes	☐ No	Did member have a contraindication to vasoreactivity test?	☐ Yes	☐ No

Was there a positive vasoreactivity test with inadequate response OR intolerance to ONE calcium channel blocker?	☐ Yes	☐ No	Is there a contraindication to use of a calcium channel blocker?	☐ Yes	☐ No

Is member pregnant?	☐ Yes	☐ No	☐ N/A	Will there be concurrent use of nitrate OR nitric oxide donors such as isosorbide mononitrate, isosorbide dinitrate OR nitroglycerin?	☐ Yes	☐ No

Does member have hepatic impairment (Child Pugh class C)?	☐ Yes	☐ No	Does member have pulmonary veno-occlusive disease?	☐ Yes	☐ No
Does member have HF with severe left ventricular dysfunction?				☐ Yes	☐ No

Additional Drug Specific Criteria

☐ **Revatio Oral Suspension**			☐ **Tadalafil**		
Was documentation presented to support inability to swallow AND necessity of brand suspension formulation?	☐ Yes	☐ No	Was documentation presented to support trial AND failure OR intolerance with sildenafil?	☐ Yes	☐ No

☐ **Adempas**

Is diagnosis of WHO PAH Group I with Functional Class II to IV symptoms?	☐ Yes	☐ No	
Member had trial AND failure with ALL preferred oral agents from each class (check that apply):	**(PDE-5) inhibitor**	**Endothelin Receptor Antagonist**	
	☐ Sildenafil	☐ Tracleer tablets	
	☐ Tadalafil	☐ Letairis	☐ Opsumit

Is diagnosis for Chronic Thromboembolic Pulmonary Hypertension WHO Group IV?	☐ Yes	☐ No	Was there recurrent OR persistent Chronic Thromboembolic Pulmonary Hypertension after surgical treatment?	☐ Yes	☐ No
Does member have inoperable Chronic Thromboembolic Pulmonary Hypertension?				☐ Yes	☐ No

☐ **Uptravi**	☐ **Orenitram**		
Does member have severe hepatic impairment (Child-Pugh class C)?	☐ Yes	☐ No	
WHO Class II and III symptoms: Member had trial AND failure with ALL preferred ORAL agents from each class (check that apply):	**(PDE-5) inhibitor**	**Endothelin Receptor Antagonist**	
	☐ Sildenafil	☐ Tracleer tablets	
	☐ Tadalafil	☐ Letairis	☐ Opsumit
WHO Class IV symptoms: Member had trial AND failure with ONE Prostacyclin:	**Prostacyclin Analog**		
	☐ Epoprostenol		

☐ **Tyvaso**	☐ **Ventavis**		☐ **Remodulin**	☐ **treprostinil**	
☐ **Tyvaso AND Ventavis:** Does member have Functional Class III-IV symptoms?	☐ Yes	☐ No	☐ **Remodulin**: Does member have Functional Class II-IV?	☐ Yes	☐ No

WHO Class II and III symptoms: Trial AND failure with ALL preferred oral agents from each class:	**(PDE-5) inhibitor**	**Endothelin Receptor Antagonist**	
	☐ sildenafil	☐ Tracleer tablets	
	☐ tadalafil	☐ Letairis	☐ Opsumit
WHO Class IV symptoms**:** Trial AND failure with ONE Prostacyclin:	**Prostacyclin Analog**		
	☐ Epoprostenol		

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Proprietary

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: _______________________________________ **Date:** ______________

<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.

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